SCHOOL OF PUBLIC HEALTH

COLLEGE OF MEDICINE AND HEALTH SCIENCES

UNIVERSITY OF GONDAR

ASSESMENT OF SKILLED DELIVERY SERVICE UTILIZATION AND ASSOCIATED FACTORS AMONG WOMEN OF CHILDBEARING AGE IN CHILGA WOREDA,NORTH GONDAR ZONE,NORTH WEST ETHIOPIA.

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ACRONYMS:

ANC – Antenatal Care

EDHS – Ethiopian Demographic and Health Survey

FMOH –Federal Ministry of Health

HFs- Health facilities

HCs –Health Centers

MDG – Millennium Development Goals

MMR – Maternal Mortality Ratio

NFHS- National Family Health Survey

PPH- Post Partum Hemorrhage

SBAs –Skill Birth Attendant

SDA-Skilled Delivery Attendants

SSA –Sub Saharan Africa

TBAs – Traditional Birth Attendants

TTBAs – Trained Traditional Birth Attendants

WHO – World Health Organization

HEWS- Health Extension Workers

VCHWs-Voluntary Community Health Workers

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ABSTRACT

INTRODUCTION: According to the recent review of the Millennium Development Goals (MDG), little progress has been made with respect to MDG 5 on improving maternal health. Skilled delivery care is considered a crucial function within the health care system for saving the lives of mothers and newborns and represents an important indicator for monitoring MDG 5. However, this service is significantly lower in Ethiopia and as well as in Amhara National Regional State.

OBJECTIVES: To assess skilled delivery service utilization and associated factors among mothers who gave birth in the last 2 years, in Chilga Woreda, North Gondar Zone, North West Ethiopia.

METHODS: A community-based cross-sectional study was conducted on mothers who gave birth in the last 2 years. Multistage sampling was used to get the total sample size of 500 participants. A pre-tested and structured questionnaire was used to collect data on skilled delivery service utilization and associated factors. Data entry was carried out using EPI info version 3.5.1 and transferred to SPSS version 16.0 soft ware packages for analysis.

RESULTS: The study indicated that 18.3% of the respondents delivered in health facilities with the assistance of skilled birth attendants and 81.7% of the mothers gave birth at home, of whom 40.7 % of them assisted by trained traditional birth attendants. Mothers who attended secondary education and above levels of education were over 2.5 times more likely to use skilled attendants than those who were illiterate (AOR=2.64 and 95% CI: 1.06, 6.57) and mothers in urban were about 14 times more likely to utilize skilled delivery attendants than those who live in rural kebeles (AOR=13.56 and 95%CI: 6.75, 27.27).

Health facility visit during last pregnancy, Number of pregnancy and attitude of the mothers towards skilled delivery service utilization were other factors which showed significant association with skilled delivery service utilization (P-value < 0.05 for each).

CONCLUSION: Skilled delivery service utilization in the study area was low. Rural mothers were less likely to use skilled attendants during their child birth in health facilities than urban counterpart.

RECOMMENDATION: increasing educational opportunities for girls, promotion of ANC follow-up with provision of MCH information particularly, the need for SDA, training in midwifery for health extension workers, the government and other responsible bodies should make efforts to increase community based health education and awareness creation programs are recommended.

1. INTRODUCTION

1.1. Statement of the problem

To date, the importance of maternal health care services in reducing maternal mortality and morbidity has received a significant recognition. Implementing and assuring utilization of effective maternity care for women in the developing world is not an easy task. In Ethiopia, as in other developing countries, most childbearing women are poor and live under harsh conditions. For them, while adequate care during pregnancy and delivery is essential, health care service utilization is extremely low. This low utilization of health care services may give some indication of service coverage in the country. As a result, each year large number of women in the child bearing ages (15-49 years) dies from complications associated with pregnancy and childbirth (1).

Among developing regions, sub-Saharan Africa had the highest MMR at 640 maternal deaths per 100 000 live births in 2008, followed by South Asia (280), Oceania (230), South-Eastern Asia (160) (2).

Despite various national and international initiatives to improve maternal health, more than half a million women from developing countries die each year as a result of complications related to pregnancy and child birth (3,4).

In Ethiopia the proportions of births attended by skilled personnel is very much lower than SSA. Even for women who have access to the services, the proportion of birth occurring in health facilities is very low. Only 6% of births were delivered in health institutions and there is no significance difference in proportion of institutional delivery service between EDHS 2000 and 2005 (5).

In Amhara region 3.7 percent of births were delivered with the assistance of a trained health professional, that is, by doctors, nurses, or midwifes, while 29.6 percent were delivered by a traditional birth attendants (TBAs). The majority of births (64.6 percent) were attended by a relative or some other person (6).

Skilled delivery service utilization was not assessed in the study area before. Therefore, this cross-sectional study was conducted to assess skilled delivery

service utilization and associated factors among mothers who gave birth in the last 2 years in Chilga Woreda, North Gondar Zone, North West Ethiopia.

1.2. LITRATURE REVIEW

1.2.1. Maternal Mortality

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (7).

Maternal health is one of the major worldwide health challenges. Currently, the unacceptably high levels of maternal mortality are a common subject in global health and development discussions (8).

Globally an estimated of 358 000 maternal deaths occurred in 2008, a 34% decline from the levels of 1990. Despite this decline, developing countries continued to account for 99% (355 000) of the deaths. Sub-Saharan Africa and South Asia accounted for 87% (313 000) of global maternal deaths (2).Even if declining maternal mortality owing to large-scale programmatic interventions over the past two decades, the progress has been slow and uneven, both across and within countries (14).

Trend analysis at global level shows that maternal mortality has decreased at an average of 2.3% annually between 1990 and 2008 far below the 5.5% annual decline, which is necessary to achieve the fifth MDG, concerning maternal mortality reduction. To achieve this goal, the maternal mortality rate needs to decrease at a much faster rate in the future especially in sub-Saharan Africa, where the highest maternal mortality is reported and where the annual decline has so far been about 1.7 % (9). Study shows that more than 50% of all maternal deaths were in only six countries in 2008 (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo) (10).

Globally approximately 80% of the maternal deaths occur due to hemorrhage, sepsis, unsafe induced abortion, hypertensive disorder of pregnancy, and obstructed labour (11); similarly in Africa the main causes are hemorrhage (34%), infection

(10%), hypertensive disorders (9%) and obstructed labor (4%). This is different from the developed countries where hemorrhage only accounts for 13% (8). These deaths are unjust and can be avoided with key health interventions, like provision of antenatal care and medically assisted delivery (12, 13).

1.2.2. Skilled delivery service utilization

A skilled attendant of delivery is defined according to the WHO as an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (15).

Experience in the developing world shows that, most women are currently delivering without a skilled attendant, but in most developed world the use of a skilled attendant is increasing (16); professionals with delivery skills (doctors, nurses, or midwifes) are in short supply in the countries with high maternal mortality rates (17, 18); and poor women are more likely to die in childbirth and less likely to have a skilled attendant present at their births (19).

Similarly, women in sub-Saharan Africa most often face suboptimal management of pregnancy and delivery complications, as only 46.5% of births are attended by a skilled health professional (34.2% and 39.6% in Eastern and Western Africa, respectively) compared with 83.2% in Latin America and the Caribbean and virtually all births (> 99%) in industrialized countries (20).A community survey, conducted in Bangladesh shows that 35% of deliveries were attended by SBAs: 22.8% at health facilities and 12.4% at home. About two-thirds of all deliveries took place at home with unskilled birth attendants (21).

Another study conducted in Indonesia shows that Most births (83%) took place at home, and only one-third of births (32.8%) were attended by a health professional (90.4% by a midwife, 7.0% by both a midwife and doctor, and 2.7% by a doctor). A few births took place in a health centre, clinic or hospital (5.8%); 11.2% of births took place in a midwife’s home (22).

Similarly population-based survey conducted in a rural area of Cambodia indicates that out Of the 980 women who delivered babies during the 3-month period before the survey, 194 (19.8%) had skilled attendants, 769 (78.5%) had unskilled attendants and 17 (1.7%) women delivered alone. Most deliveries (88.1%) took place at home (23).

A population-based survey conducted in western Kenya shows that most women (83%) delivered outside of a health facility. Of these, 80% delivered in their own house, 18% in the house of a TBA and 3% on their way to a health facility. Among all deliveries of women, only 17% were attended by a professionally trained provider (doctor, nurse, midwife, or clinical officer) and TBAs assisted another 36% of women. A disturbingly high proportion of women (29%) were attended to by an untrained family member, friend or neighbor, and 18% of women delivered completely unattended (24).

Regarding Ethiopia, the 2005 EDHS data show that most deliveries still occur at home and are assisted by medically unskilled birth attendants. Among all live births in the five years preceding the survey, almost 95 percent took place outside a health facility. The proportion of births delivered at health facilities in urban areas is by far higher than rural areas (42.6 percent and 2.4 percent, respectively). Births at home are substantially higher among women who live in Tigray, Afar, Amhara, Oromia, Benishangul Gumuz and SNNP regions. On the other hand, relatively large proportions of women give birth in health institutions in Gambella (16.1 percent), Harari (31.8 percent), Addis Ababa (78.4 percent) and Dire Dawa (26.3 percent) (1).

1.2.3. Factors affecting delivery service utilization

I. Socio-demographic factors

At the individual level, socio demographic factors, such as wealth and education, are most important and directly determining health services utilization during delivery (25-27).

The National Family Health Survey (NFHS) conducted in rural India shows that, among the least privileged households, those with poorest access, wealth and education, only 10-15% of births were delivered in a medical facility. This proportion

rises to 32% among households living within 5 km of a hospital, to 44% among the richest households and to 67% among the small minority of households where the mother has tertiary education (28).

A cross sectional study done in southern Tanzania revealed that the proportion of women who were attended during delivery by a skilled attendant was seen to decrease significantly with increasing age of women from 57.5% among women below 20 years of age to only 48.8% among women aged 35 or more years. Years spent in school also showed a significant association with seeking of skilled care during delivery with women who have more schooling years having a higher proportion of deliveries (50.4%) attended by skilled personnel compared to those with fewer schooling years or those who did not go to formal schooling (29).

Analysis based on Ethiopia DHS shows that women with partners who had a secondary or higher education had two times higher odds of delivering with professional assistance when compared to those with partners having no education (30).

According to Ethiopia Demographic and Health Survey 2005 Mother's education has a positive relationship with delivery care. Births to women with primary education are almost four times (9 percent) more likely and births to women with secondary or higher education are 25 times (58%) more likely to receive delivery assistance from a health professional than births to women with no education (2%). Similarly, assistance by a trained health professional varies by economic status of women. Births to women in the highest wealth quintile are much more likely to be assisted by a trained health professional (27%) than births to women in the lowest wealth quintile (1%).Deliveries by caesarean section are not common in Ethiopia. If they do occur, they are mostly among highly educated women (13%), urban women (9%), and women in Addis Ababa (16%) (6).

A community-based cross-sectional survey done in Samre Saharti District, Tigray, Ethiopia shows more than one third (40.6%) of mothers with secondary education were assisted by skilled birth attendants compared with illiterate mothers (4.6%). Mothers with primary education had a 2.6 times higher risk to be assisted by skilled

birth assistances than those who were illiterate. Mothers with secondary education were more likely to be assisted by skilled birth attendant than those who were illiterate (31).

II. ANC service utilization

Antenatal service is important as it offers pregnant women an opportunity to get different services which alerts the woman to the risks associated with pregnancy and for discussing her options for safe delivery (32, 33). Antenatal care attendance was a significant determinant of facility delivery. However, this was the case only when attendance was four times or more (23).

A cross-sectional, cross-country analysis revealed that the proportion of antenatal care users who delivered their youngest child in a health centre varied widely between countries, ranging from 29% in Ethiopia to 92% in Congo Brazzaville. Receiving advice and information on pregnancy complications increases the likelihood of institutional delivery in all countries except Congo Brazzaville and possibly Chad. Among women who attended just one antenatal visit, those who received advice were 70% more likely to have institutional deliveries compared with single-antenatal-care users with no advice. Likewise, compared with those who had only one antenatal visit but no advice, women who had at least five antenatal visits were 3.82 times more likely to have institutional deliveries, whereas those who additionally received advice were 4.81 times more likely to deliver institutionally (34).

Another study conducted in Nigeria indicated that about three-fifths (60.3%) of the respondents used antenatal services at least once during their most recent pregnancy, out of which the percentage of last births whose delivery was assisted by qualified medical personnel (doctor, nurse or nurse-midwife) was 43.4% (35).

A similar study conducted in Nairobi, Kenya pointed out, women reporting four or more antenatal visits were more likely to deliver in an “appropriate” health facility (52%) than their counterparts who made only two to three visits (48%) or one visit or none (35%) (36).

Prospective follow up study conducted in Jima town shows that ANC attendance during pregnancy is significantly associated with women's place of delivery and women who were attending ANC follow up during the current pregnancy, are 3 times more likely to deliver in HFs when compared to women who were not attending ANC (37). Similarly a community-based cross-sectional survey done in Tigray, indicates that mothers who had antenatal visit were more likely to be assisted by skilled birth attendants than women who did not have ANC visit (31).

III. Obstetric factors

A community based cross-sectional study conducted in Afghanistan indicated that Women aged 30 to 39 years had lower odds of skilled birth attendant use than did younger women, but no statistical difference was evident between women older than 39 years compared with women younger than 30 year (38).Similar study conducted in Bangladesh shows that skilled attendance at birth was 48% among mothers who reported at least one complication during pregnancy or the delivery period compared with 23% among those who do not (6).

The data also show that women are more likely to seek delivery care for their first birth than any other subsequent birth orders. Taking the second and third birth orders as a reference category, the net odds of seeking delivery care for the first births is 2.41 times higher than that of the reference category. Women with higher birth orders of four and above are less likely to seek delivery care at a health facility as compared to the reference category. Young women, particularly for their first delivery, tend to give birth at health institutions with the help of health professionals (1).

Similarly, study conducted in Tigray shows that, low parity was found as one of the most important predictors of delivery place preference. Women with 8-11 children had less odd of selecting HF for delivery services than women with 1-4 children. Similarly Women who had a history of obstructed labor were more likely to select HF for delivery service than women who had not that experience (31).

1.3. Justification

In Ethiopia despite low utilization of health care services, there is considerable variation across different demographic and socio-economic variables. The explanation of this diversity may be complex. Utilization of maternal health care services is affected by a multitude of factors. An attempt was made in this study to investigate the factors that determine women's skilled delivery services utilization.

Studies conducted so far on skilled delivery service utilization and determinant factors in Ethiopia were few in number and some of the studies were old which may not show the present reality and there was no study conducted in the particular study area on the same topic, then this study will provide valuable information for the study area or for the country at large.

2. OBJECTIVES

2.1. GENERAL OBJECTIVE

- To assess skilled delivery service utilization and associated factors among mothers who gave birth in the last 2 years in Chilga Woreda, North Gondar Zone, North West Ethiopia.

2.2. SPECIFIC OBJECTIVES

- To determine the level of skilled delivery service utilization among mothers who gave birth in the last 2 years.
- To identify associated factors affecting skilled delivery service utilization among mothers who gave birth in the last 2 years.

3. METHODS

3.1. Study design

A community- based cross-sectional study was conducted among mothers who gave birth in the last 2 years in Chilga Woreda, North Gondar Zone, North West Ethiopia.

3. 2. Study area and period

The study was conducted from April to June/2011 in Chilga Woreda, which is among twenty four woredas in North Gondar Administrative Zone. The capital of Chilga is Aykel, which is located around 783 Km from Addis Ababa, 243 km from Bahirdar and 63 Km from Gondar town .The Woreda is bounded by Takusa & Alefa woreda in the South, Lay and Tach Armachiho in the North, Gondar town administration in the East and Metema Woreda in the West. Based on 2010 estimation the woreda has a total population of 237,490, out of which 120,032 and 117,458 were male and female population respectively and the number of child bearing women (15-49 years) is 54,019. The population is inhabited with an estimated area of 322,264.08 square kilometers. And about 24,456 (10.3%) of the population is urban inhabitant. The Woreda has 45 rural and 2 urban kebeles with five functional and two under construction health centers.

3.3. Source population: All women who gave birth in the last 2 years in the Woreda.

3.4. Study population: The study population includes all mothers who had given birth in the past two years in the selected kebeles. The study units were mothers in the selected households.

Inclusion criteria: women who gave birth in the past 2 years regardless of the outcome and who lived in the study area for at least six months.

Exclusion criteria: Mothers who are not mentally healthy and unable to hear were excluded from the interview.

3.5. Sample Size and Sampling techniques

I. Sample size: The required sample size of the study participants was determined by single population proportion formula.

Assumptions;

n = the number of mothers to be interviewed;

Z = standardized normal distribution value for the 95% CI, which is 1.96

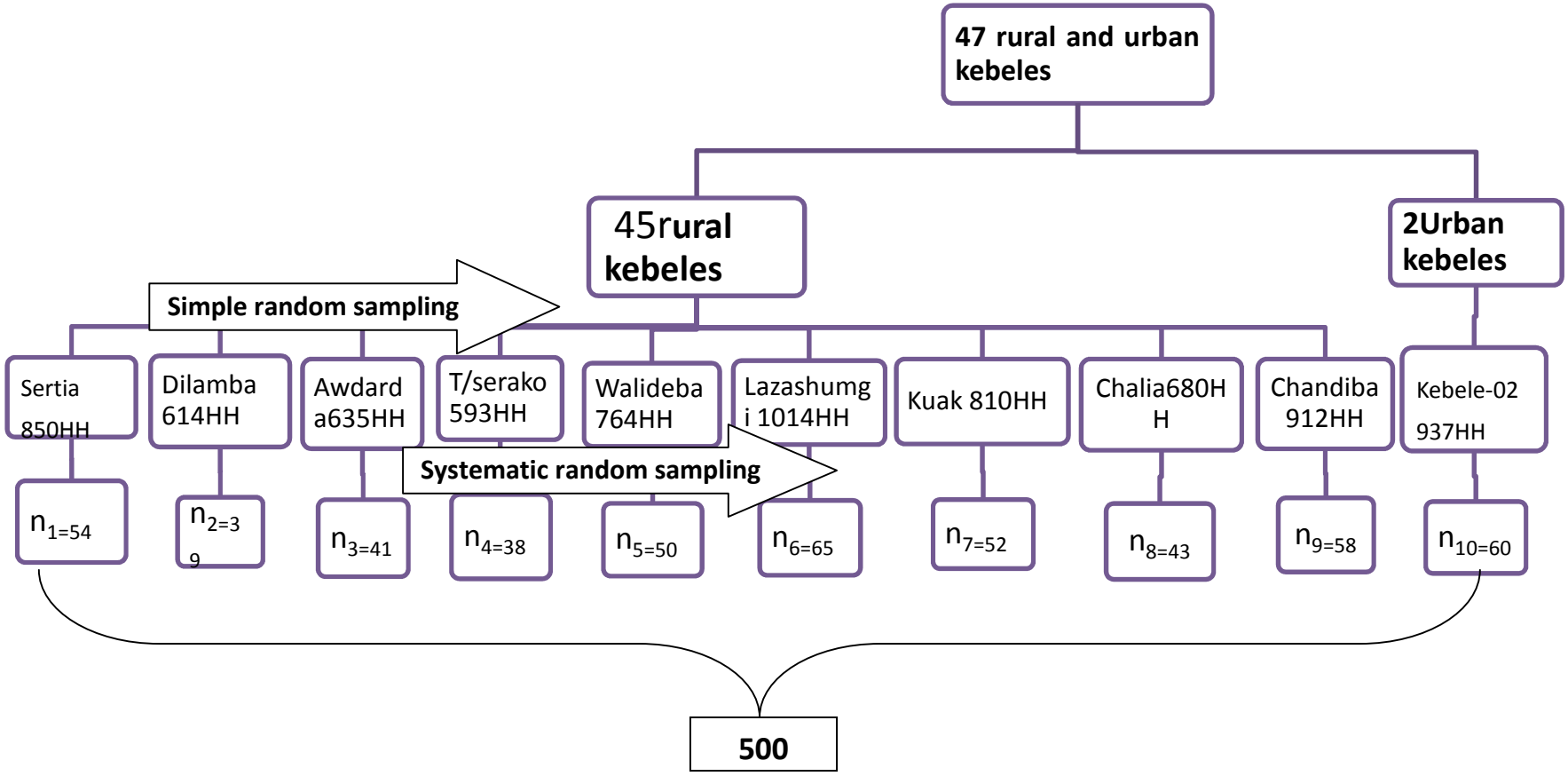
P = 17.9% (proportion of mothers who gave birth with skilled attendant in Amhara region) (39).

d = the margin of error is taken as 5%

$$n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2} = \frac{(1.96)^2 (0.18)(0.82)}{(0.05)^2} = 227$$

Since multistage sampling technique was used the sample size was multiplied by the design effect to get the final sample size. By taking the design effect as two, the required sample size was 454. After 10% of non response rate for mothers who either refuse to participate or may not be available after frequent attempts, the final sample size was 500.

II. Sampling techniques: Multistage sampling technique was used to select the study population. Initially, the study area was divided in to two strata, urban and rural kebeles. For logistical and cost reasons one urban kebele and nine rural kebeles were selected by simple random sampling technique. Households from each kebele were proportionally selected by systematic random sampling technique. If there was more than one mother within the same household lottery method was used to select the mother to be included. To determine the direction and starting point of the household, spine the pen technique was applied (in the direction the ballpoint of the pen is pointing).


47 rural and urban kebeles
45rural kebeles
2Urban kebeles
Simple random sampling
Sertia 850HH
Dilamba 614HH
Awdarda635HH
T/serako 593HH
Walideba 764HH
Lazashumgi 1014HH
Kuak 810HH
Chalia680HH
Chandiba 912HH
Kebele-02 937HH
Systematic random sampling
n1=54
n2=39
n3=41
n4=38
n5=50
n6=65
n7=52
n8=43
n9=58
n10=60
500

3.6. Study variables

Dependent variable: skilled delivery service utilization (Code Home=0,Health facility=1)

Independent variables:

Socio demographic variables:-(age of the mothers, marital status, place of residence, family income, educational status of the mothers, educational status of the husband, distance of health facility, family size, occupation of the mother, occupation of the husband, religion, age of the husband, possessing media of communication).

Obstetrics factors :-(Age at first union, age at first pregnancy, ANC visit, parity, gravidity, history of abortion, history of still birth, assistance at delivery).

- Knowledge and attitude of the mother towards giving birth in health facilities.
- Decision making autonomy of the mother.

3.7. Operational definitions:

Skilled birth attendance: People with midwifery skills (doctors, midwifes, nurses) who have been trained in the skills necessary to manage normal delivery, diagnose and refer obstetric complications.

Untrained traditional birth attendants: Birth attendant who initially acquired the ability by delivering babies herself or through apprenticeship to other TBAs.

Trained traditional birth attendants:Those TBAs who have undergone subsequent training by the government and are integrated in the formal health care system.

knowledgeable: Those mothers who score mean value and above to questions asked on pregnancy and delivery related services, advantages of these services, pregnancy and delivery related complications and mothers susceptible to these complications.

Not knowledgeable: Those mothers who score below mean value to questions asked on pregnancy and delivery related the services, advantages of these services, pregnancy and delivery related complications and mothers susceptible to these complications.

Positive attitude: Those mothers who score the mean value and above to questions asked on institutional delivery, skilled birth attendants and home delivery.

Negative attitude: Those mothers who score below mean value to questions asked on institutional delivery, skilled birth attendants and home delivery.

3.8. Data collection Procedures

Data was collected by face to face interview using a structured and pre-tested questionnaire. The questionnaire was first prepared in English and translated to Amharic finally it was translated back to English by another person for consistency. Socio demographic, obstetrics, knowledge and attitude of the mother and women's decision making autonomy variables were addressed by the questionnaire. Eight 12^{th} grade completed students in the town were selected as data collector and three supervises (two Bsc nurses and one Environmental health worker) from Chilga woreda Health office were assigned to the data collection process.

3.9. Data quality control

The quality of data was assured by proper designing and pre-testing of the standard questionnaires in the area that was not included in the main study with similar socio-demographic characteristics to ensure its validity. Training was given for both data collectors and supervisors by the principal investigator for a day before and one day after pretest. The training included discussion on the objectives of the study and on the contents of the questionnaire one by one, on procedures, and data collection techniques and on the issues of the confidentiality of the responses. For verification purposes 5 % of study subjects was selected randomly for re-interviews and for controlling errors 10% of the questionnaire was double entered and frequency checks were also done. Every day after data collection, questionnaires were reviewed and checked for completeness by the supervisors and principal investigator and the necessary feedback was offered to data collectors in the next morning.

3.10. Data Processing and Analysis

All the questionnaires were checked visually for some inconsistencies and incompleteness in the data set, coded and entered into EPI info version 3.5.1 and it was transferred to SPSS version 16.0 soft ware packages for analysis. The data was analyzed using logistic regression to determine the effect of various factors on the outcome variable and to control confounding effects. The results were presented in the form of tables, figures and text using frequencies and summary statistics such as mean, standard deviation and percentage to describe the study population in relation to relevant variables. The degree of association between independent and dependent variables were assessed using odds ratio with 95% confidence interval.

3.11. Ethical Considerations

The proposal was reviewed and approved by the Institutional Review Board (IRB) of University of Gondar and permission to conduct this study was also obtained from Chilga Woreda administrator and Woreda Health Office. All selected participants were communicated about the study in order to obtain their verbal consent before administering questionnaires. Participants were also informed that they had full right to discontinue or refuse to participate in the study. They were also informed that all data obtained from them would be kept confidential. Each respondent was informed about the objective of the study that contributes necessary information for policy makers and other concerned bodies.

6. RESULTS

1. Socio-demographic Characteristics of the Respondents

Out of 500 households were sampled 480 mothers who gave birth in the last 2 years were interviewed. There for the response rate was 96%. Out of these, 420(87.5%) and 60 (12.5%) were rural and urban residents, respectively.

Most (55.9%) of the respondents were in the age group 25-34 years with mean age of 28.1 ± 5.9 SD .The majority (81.2%) of the study subjects were housewives. Among the interviewed mothers 111(23.1%) have primary education and 45(9.4 %) were with secondary education and above and the rest 324(67.5%) were with no education.

Majority (95.4%) of the study participants were Orthodox Christians while the rest were Muslims. All of the study participants were from Amhara ethnic group. Regarding their marital status, majority 443(92.3%) of them were married.

Regarding their husband educational status 242(54%) of them have primary education followed by 170(38 %) of them were unable to read and write the rest 36(8%) of them have secondary and above. Most (83%) of husband's occupational status were farmers.

Concerning distance from the nearby health center, 181(37.7%) lived in less than one hour on foot travel distance and 169(35.2%) were between one to two hours distance far the rest 27.1% were in more than two hours travel distance and the mean numbers of people living in a household were 5.66±2.15 SD **(see detail in Table 1).**

Table: 1. Selected Socio-demographic characteristics of respondents in Chilga woreda North Gondar Zone, North West Ethiopia, August 2011.

Variables	Number(N=480)	Percent
Place of residence		
Urban	60	12.5
Rural	420	87.5
Age of mother at interview (Mean SD,28.14 ± 5.94)		
15-19	23	4.8
20-24	100	20.8
25-29	152	31.7
30-34	116	24.2
>35	89	18.5
Age of the husband(n=448)(Mean SD, 35.50 ±7.72)		
15-19	3	0.6
20-24	17	3.5
25-29	68	14.2
30-34	127	26.5
>35	233	48.5
Marital Status		
Married	443	92.3
Divorced	22	4.6
Widowed	2	0.4
Single	8	1.7
Separated	5	1.0
Maternal education		
Unable to read & write	324	67.5
Primary education(1-8)	111	23.1
Secondary education and above	45	9.4
husband education (n=448)		
Unable to read & write	170	38
Primary education	242	54
Secondary education and above	36	8
Maternal occupation		
House wife	390	81.2
Gov't & private employed	9	1.9
others*****	81	16.9

husband occupation (n=448)		
Farmer	372	83
Gov't & private employed	26	5.8
others**	50	11.2
Distance from nearby HC		
Less than one hour	181	37.7
One to two hour	169	35.2
More than two hour	130	27.1
Family size (mean with SD, 5.6±2.1)		
1-5	217	45.2
>5	263	54.8
Monthly income		
<500 birr	262	54.6
500-1000birr	193	40.2
>1000birr	25	5.2

2. Obstetric characteristics of the respondents:

The mean age at first union was 17 years and 368 (78%) of them had their first union between the age of 15 and 19 years and 64(13.3%) women at the age of <15 years. The mean age at first pregnancy was 18 years and 237 (49.4%) women's were become pregnant at the age of <20 years and 223 (46.4%) were between the age of 20 and 24 years.

For 90(18.8%) mothers the last pregnancy was their first, 268 (55.8%) of them have 2 to 5 and 122(25.4%) of them have more than 5 pregnancies. Majority of respondents (57.5%) have 2 to 5 children and 111 (23.1%) have >5 children. About 381(79.4%) of respondents attended antenatal care in their last pregnancy. Among mothers who attained ANC for their last pregnancy, 236 (75.4%) attained 2–4 times whereas, 58 (18.6%) and 19(6%) attained one and more than 5 times respectively.

Among who visited health facilities for antenatal care, 217(69.3%) got some information about pregnancy & delivery Complications. Out of the total respondents only 88 (17.7 %) of them gave birth with the assistance of skilled attendants in health facilities, only 3(0.6%) of them gave birth in their home with skilled birth attendants and the majority of them (81.7%) delivered at home without skilled professionals. Among those who delivered in health facilities, 68(80%) were in health centers and the rest 20 % were in hospital **(see detail in table 2).**

Table: 2. Selected Obstetric characteristics of respondents in Chilga woreda North Gondar Zone, North West Ethiopia, August 2011**.**

Variables	**Number** (N=480)	**Percent**
Age at first union (Mean 17,with SD=2.4)		
<15	63	13.3
15-19	368	78
≥ 20	41	8.7
Age at first pregnancy (Mean 18.4, with SD=2.6)		
15-19	237	49.4
20-24	223	46.4
≥ 25	20	4.2
Gravidity (Mean 4.03,with SD=2.37)		
1	90	18.8
2-5	268	55.8
>5	122	25.4
Parity (Mean 3.88, with SD=2.26)		
1	93	19.4
2-5	276	57.5
>5	111	23.1
Abortion in life time		
Yes	56	11.7
No	424	88.3

Still birth in their life time		
Yes	28	5.8
No	452	94.2
Health facilities visit during pregnancy in their life time (n=390)		
Yes	309	79.2
No	81	20.8
Any visit of health facilities during their last pregnancy (n=480)		
Yes	381	79.4
No	99	20.6
Number ANC visit during last pregnancy (n=313)		
Only one	19	6.0
Two to four	236	75.4
More than four	58	18.6
Place of last delivery		
Home	392	81.7
*Health facility	85	17.7
Home with skilled attendants	3	0.6
Assistant during Delivery at home (n=395)		
Trained traditional birth attendant(TTBA)	161	40.7
Traditional birth attendants(TBA)	98	24.8
Families	97	24.4
Health extension workers	31	8
Health worker	3	0.8
No one	5	1.3

* = Health center and hospital

Among those mothers who visited health facilities, the reasons for visiting health facilities during the last pregnancy includes for ANC services, for delivery, for problems related to pregnancy and for problems not related to pregnancy **(Figure 2).**

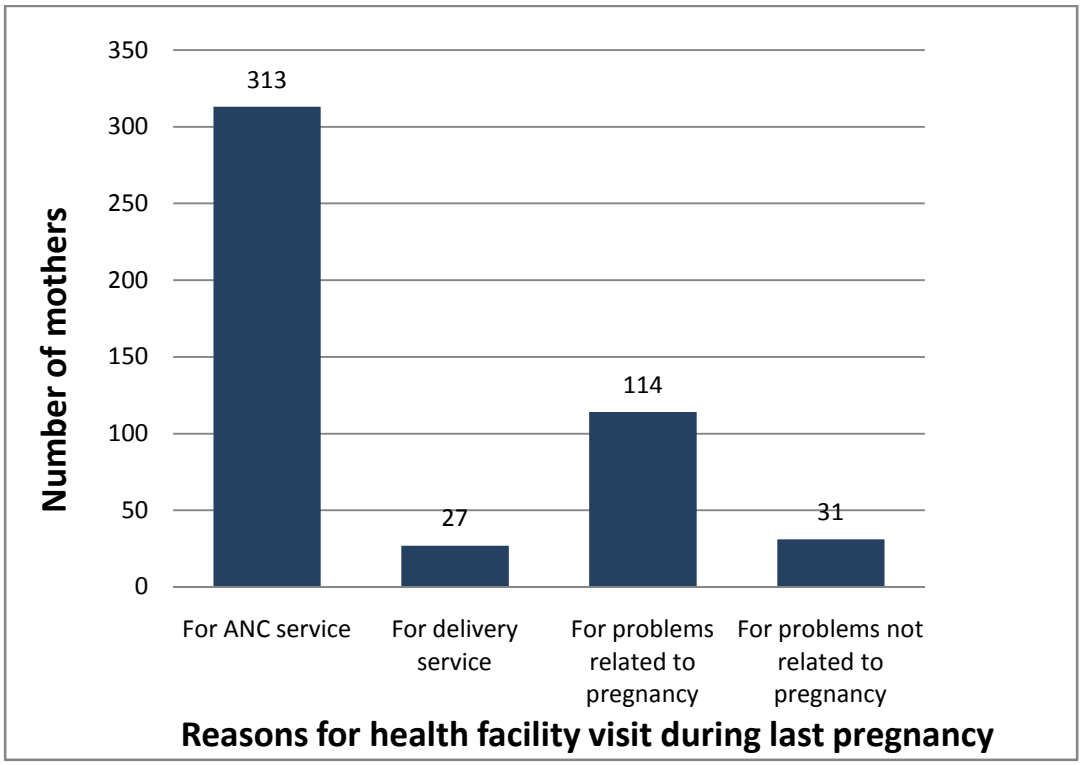


Figure 2. Reasons for health facility visit during the last pregnancy among mothers who gave birth in the last 2 years, in Chilga Woreda, North Gondar Zone, August 2011.

During ANC follow up respondents got different types of information about pregnancy and delivery complications such as severe vaginal bleeding, severe headache, fast and marked weight gain, fetal movement cessation and others **(Figure 3).**

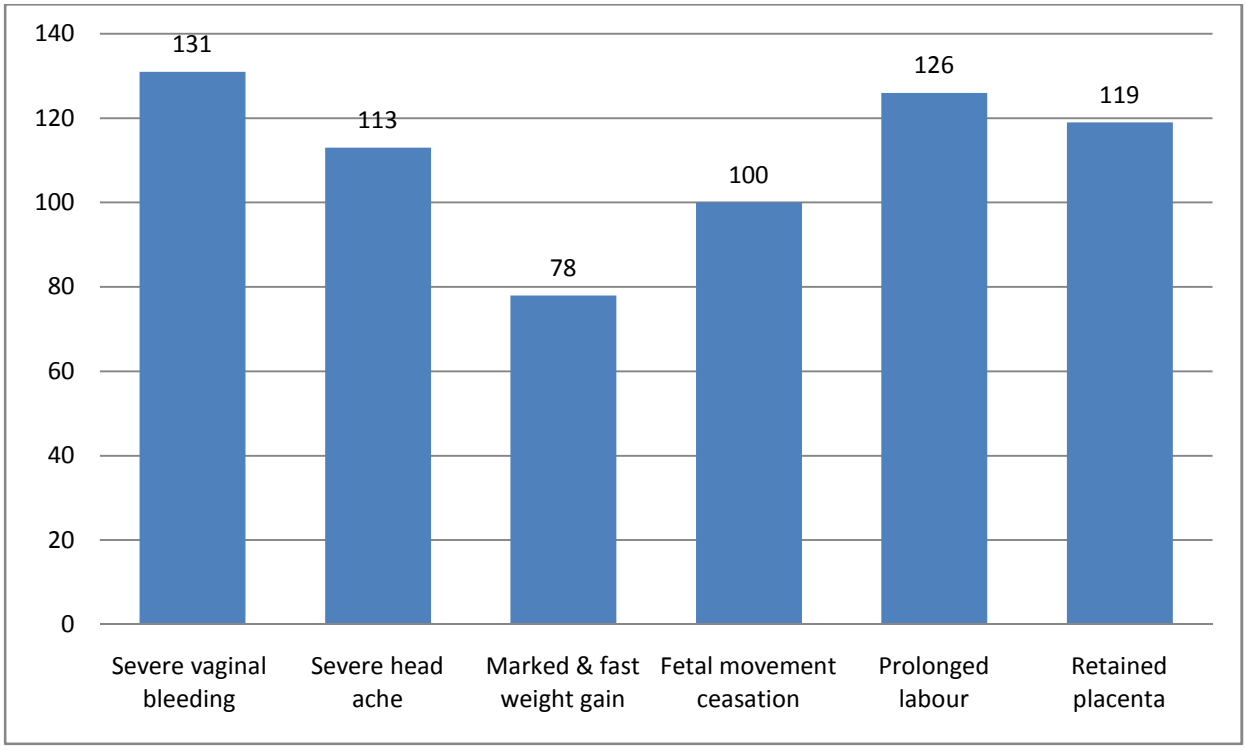


Figure 3. Graph showing types of information they got during health facility visit among mothers who gave birth in the last 2 years in Chilga Woreda, North Gondar Zone, August 2011.

Reasons given for home delivery includes, short labor 258 (66.3%), usual practice 185 (47.5%), closer attention from relatives & family members 128 (33.6 %), too far health facility 99(25.2%), feeling of more comfortable just being at home 96 (24.3%), influence from family members 25(6.4%), Unwelcome service of health workers 17(4.4%) **(Figure 4).**

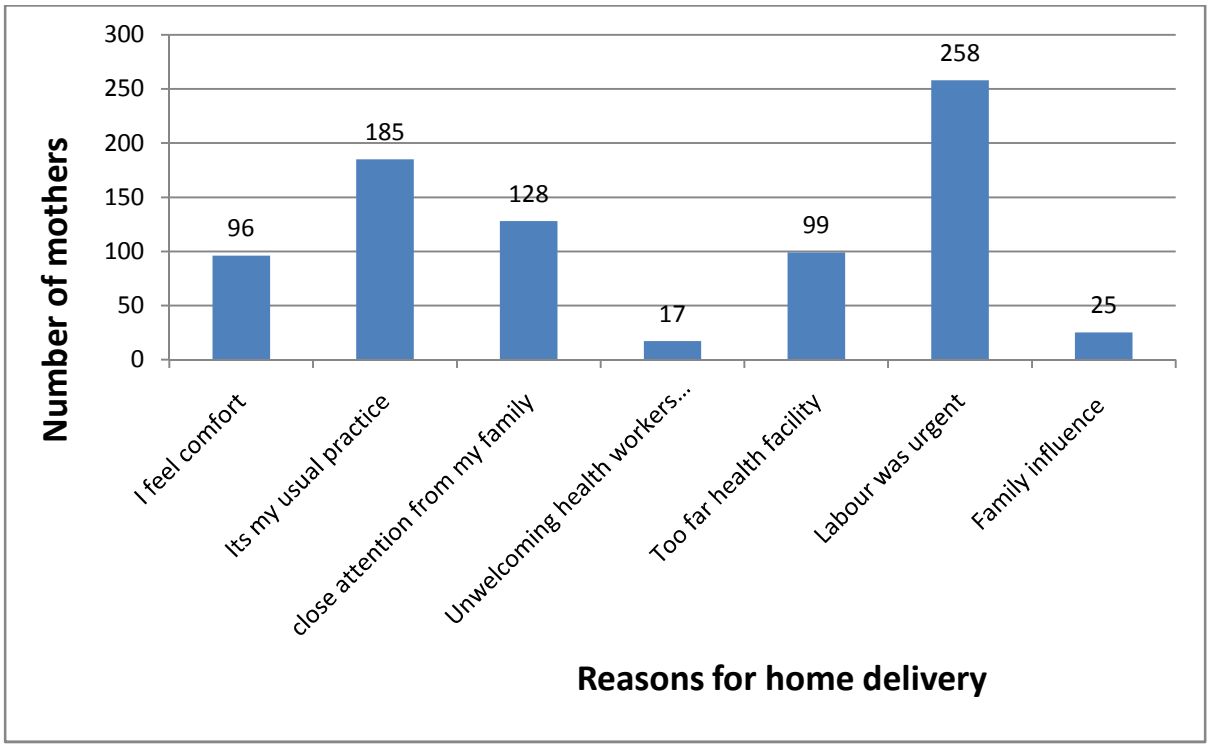


Figure 4, Reasons for home delivery among mothers who gave birth in the last 2 years in Chilga woreda, North Gondar Zone, August.2011.

Regarding preference of place of delivery during their last pregnancy, 338(70.4%) mothers preferred to deliver at home and 142(29.6%) in health facilities with the assistant of skilled professionals. Similarly, 71.5% of their husbands preferred at home, the rest 28.5% were in health facilities. In the same way, majority (83.5%) of the family members preferred for the mothers to give birth at home during the last pregnancy.

Regarding to preference of delivery attendants during their last pregnancies 170(35.4%) mothers preferred to be assisted by trained traditional birth attendants,130(27.1%) were by skilled birth attendants and 107(22.3%) were by family members. Concerning their husband's preference of delivery attendants 169(35.2%) preferred trained traditional birth attendants but 28.1% of them preferred to be assisted by skilled attendants. Regarding women decision making power in relation to getting skilled delivery services utilization, 31.9% decided by themselves, 13.5% by husbands only, 27.7% by husband and wife and 26.9% were by other family members and relatives **(Table 3).**

Table. 3. Preference of the respondents, their husband and family members about place and attendants of delivery during their last pregnancy in Chilga woreda North Gondar Zone, North West Ethiopia, August 2011.

Variables	**Number (N=480)**	**Percent**
Discussions with partner about place of delivery during last delivery		
Yes	196	40.8
No	284	59.2
Preference of the mother about delivery place during her last pregnancy		
Health facility	142	29.6
Home	338	70.4
Preference of the mother about attendant of delivery during her last pregnancy		
SBA	130	27.1
TTBAs	170	35.4

TBAs	70	14.6
Family members	107	22.3
HEWs	3	0.6
Preference of the husband about place of delivery during her last pregnancy		
Health facility	137	28.5
Home	343	71.5
Preference of the husband about delivery attendant during her last pregnancy		
SBA	135	28.1
TTBAs	169	35.2
TBAs	69	14.4
Family members	104	21.7
HEWs	3	0.6
Preference of other relatives about place of delivery during her last pregnancy		
Home	401	83.5
Health facility	79	16.5
Final decisions about place of delivery during last pregnancy		
By the mother	153	31.9
By the husband	65	13.5
Both	133	27.7
By relatives	129	26.9
Knowledge of the mother		
Knowledgeable	411	85.6
Not Knowledgeable	69	14.4
Attitude of the mother		
Favorable	377	78.5
Unfavorable	103	21.5

3. Factors Associated with skilled delivery Service Utilization

The effects of different independent variables were tested for their association with skilled delivery service utilization by logistic regression analysis. Firstly, the association of each explanatory variable with the dependent variable was checked individually using bivariate analysis, and then variables with p-value less than 0.2 were entered into the multiple logistic regression analysis to control for confounding.

By multivariate analysis when they were adjusted for other socio demographic variables only residence, maternal education, number of pregnancy, health facility visit during pregnancy and women attitude towards skilled delivery service were significantly associate with mothers skilled delivery service utilization (P-value <0.05).

Mothers from urban residents were above 13 times (AOR=13.56 and 95%CI: 6.75, 27.27) more likely to be assisted by skilled attendants than rural mothers. Mothers with secondary and above level of education (AOR=2.64 and 95% CI: 1.06, 6.57) were about 3 times more likely to be assisted by skilled birth attendants than those who were illiterate.

Women with first pregnancy (AOR=3.86, and 95% CI: 1.49, 10.01) were 4 times more likely to be assisted by skilled birth attendants for delivery services than women with more than 5 pregnancy.

Any visit to health facility is significantly associated with utilization of skilled delivery attendant. Those who visit health facilities were over 2.5 times more likely to utilize skilled delivery attendant than those who did not visited (AOR=2.59 and 95% CI: 1.08, 6.20).

Mother's attitude also a factor associated with utilization of skilled attendances at birth. Mother with positive attitude (AOR=3.98 and 95% CI: 1.04, 15.19) towards skilled delivery service utilization were 4 times more likely to deliver with skilled birth attendants than women with negative attitude **(Table 6).**

Table 6: Factors associated with skilled delivery service utilization among respondents in Chilga woreda, North Gondar Zone, North West Ethiopia, August 2011.

Variables	Skilled delivery service utilization		AOR(95% CI)	P- value
	yes	No		
Residence				
Urban	41	19	**13.56(6.75,27.27)**	**<0.001**
Rural	44	376	**1.00**	
Age of mother				
15-24	39	84	1.91(0.57,6.4)	
25-34	39	228	1.63(0.58,4.58)	
35 & above	7	83	1.00	
Monthly income				
<500	31	231	1.00	
500-1000	49	144	0.74(0.35,1.56)	
>1000	5	20	0.19(0.03,1.02)	
Maternal education				
Unable to read &write	34	290	1.00	
Primary school	26	85	**1.70(0.87,3.32)**	
Secondary & above	25	20	**2.64(1.06,6.57)**	**0.036**
Husband education				
Unable to read &write	16	157	0.49(0.12,1.89)	
Primary school	47	205	0.42(0.08,2.19)	
Secondary & above	15	19	1.00	
Maternal occupation				
House wife	7	323	1.00	
Gov't &private employ	6	3	1.04(0.45,2.39)	
Others(merchant, daily laborer)	12	69	2.45(0.45,2.39)	
Health facility distance				
< 1hr	62	119	1.61(0.74,3.48)	
1-2 hrs	9	160	0.51(0.20,1.27)	
>2hrs	14	116	1.00	

Number of pregnancy(gravidity)				
1	38	52	**3.86(1.49,10.01)**	**0.005**
2-5	38	230	1.25(0.55,2.86)	
>5	9	113	1.00	
Number of ANC visit				
1 time	3	16	0.46(0.18,1.18)	
2-4 times	43	193	0.45(0.21,1.02)	
>4 times	23	35	1.00	
Health facility visit during last pregnancy				
Yes	77	304	**2.59(1.08,6.2)**	**0.033**
No	8	91	1.00	
Attitude of mothers				
Positive attitude	82	340	**3.98(1.04,15.19)**	**0.043**
Negative attitude	3	55	1.00	

- *Back ward stepwise multiple logistic regression was used to assess the independent effect of explanatory variables.*

7- DISCUSSION

This community–based study has attempted to identify the magnitude and factors associated with skilled delivery service utilization among mothers who gave birth in the last 2 years in Chilga woreda North Gondar Zone. The study results showed that skilled delivery service utilization was 18.3% in the woreda, the majority of mothers (81.7%) gave birth at home, which is higher than EDHS (6%).

This might be methodology difference, socio-demographic characteristics and cultural difference in the study area and another difference may be because of the health extension package implementation and accessibility of health institution at grass root level. Similarly, this finding is also higher than study conducted on assessment of safe delivery utilization in North Gondar and Determinants of Skilled Birth Attendant Utilization in Afghanistan which is 13% and 13.5% respectively (38,40). This may be due to socio-demographic characteristics and the difference in the awareness of the community, But consistent with studies done on determinants of skilled birth attendance in rural Cambodia and use of antenatal and delivery care service in Western Kenya (19.8 % and 17 respectively) (23, 24).

But it is much lower than other studies done in Mekele and Jima towns 67.4% and 69.3% respectively (37,44). The possible reason for the discrepancy could be that this study was conducted in rural areas; however, those studies conducted exclusively in urban areas with referral Hospital and many health facilities found in it.

Three hundred ninety two mothers (81.7%) gave birth at home, 88(18.3%) at health institution, like health center and hospital. From mothers who gave their last birth at home, 161(40.7%) conducted by TTBAs, 98(24.8%) by TBAs, 97(24%) by family members, 31(13%) by HEWs, 5(1.3%) without any assistance and 3(0.8%) by skilled attendants.

A population-based survey conducted in western Kenya showed that most women (83%) delivered outside of a health facility. Among all deliveries of women, only 17% attended by professionally trained providers and TBAs assisted another 36% of women. High proportions of women (29%) attended by an untrained family member, friend or neighbor, and 18% of women delivered completely unattended (24).

Both trained and untrained traditional birth attendants have been part of the community for a long time, this profession has been handed over from one generation to another. This study also showed that their role was still prominent (more than 65% delivery assistance). The possible explanation might be; their long experience in providing services to mothers and infants, their intimacy with the villagers, and acceptance by the community which created loyalty and understanding, this built the authoritative knowledge conferred on them by the community.

In this study, reasons given for home delivery includes, short labor 258 (66.3%), usual practice 185 (47.5%), closer attention from relatives & family members 128 (33.6 %), too far health facility 99(25.2%), feeling of more comfortable just being at home 96 (24.3%), influence from family members 25(6.4%), Unwelcome service of health workers 17(4.4%); which is consistent with findings from studies conducted on utilization of skilled birth attendant at delivery in Mekele and Survey of Home Delivery and Newborn Care Practices in Western Nigeria (44,45).

The main purpose of this study was to identify determinants that influence the use of skilled birth assistance; so the study has been identified several variables that have important influence on utilization of skilled delivery attendant. It revealed women's education, residence, gravida (total number of pregnancy), any visit to health facility during last pregnancy, and women attitude towards skilled delivery service utilization as influencing factors for utilization of skilled delivery attendant. Most of these findings are consistent with previous studies (1, 35, 37 40, 41, 43 and 44).

As many study findings indicate, this study also revealed that those who live in urban were almost 14 times more likely to utilize skilled delivery attendants than those who live in rural kebeles.

In study done in Namibia, on equities in utilization of maternal health interventions indicate that women in urban areas delivered by skilled providers 30% more than their rural counterparts (43). It is also consistent with the study done on maternal health care seeking behavior in Ethiopia, findings from EDHS 2005, which revealed that the proportion of births delivered with skilled birth attendants in urban areas is by far higher than rural areas (42.6 percent and 2.4 percent, respectively)(1).

The reason might be the fact that in urban areas the proportion of mothers with education is higher, they tend to have better access to health facilities and other promotional activities that are usually urban based and also mothers have better decision making autonomy than rural mothers.

This study illustrated a wide variation in use of skilled attendant between educated and illiterate mothers. Mothers who attended secondary education and above levels of education were 3 times more likely to use skilled attendants than those who were illiterate.It is consistent with findings from studies done on institutional delivery in rural India and on equities in utilization of maternal health interventions in Namibia.(28,43).It is also consistent with other studies conducted in Tigray Samre Sharti district (13.5 times),Jima (5 times) and Mekele (4 times) more likely to use skilled attendants than those who were illiterate (31,37,44).

There are reasons of why education influences the use of skilled attendants. Educated women are expected to have knowledge and awareness about the advantages of the interventions and pregnancy related complications, they are more likely to seek modern health care than those who are not. And education is likely to improve the general status of women and help them to build up confidence to make decisions about their own health.

Gravidity is another obstetric variable found to be significantly affecting the utilization of skilled delivery attendant. Women's with first pregnancy were four times more likely to utilize skilled delivery attendant as compared to those who were pregnant more than 5. This finding is consistent with other studies, which indicated that women's are more likely to utilize professional assistance for their first births (1, 31, 40, and 44).The possible explanation for selection skilled attendants for delivery services among women with first pregnancy implies that those women might be younger and has better understanding about the advantages of maternal health care. In addition, women with first pregnancy might look for delivery assistance due to their less experience in child birth that might develop fear about the difficulties during labor. This could motivate them to seek maternal health care. The other possible explanation for the low utilization of maternal health care services among higher parity women could have more experience on child birth and they might think

delivery is normal and develop self-reliance and preferred to give birth at home with mothers and relatives assistance. A study in India also revealed that women's are more likely to get care for their first delivering than others that follow (39% versus 9%)(28).

Any visit to health facility is significantly associated with utilization of skilled delivery attendant. Those who visit health facilities were almost three times more likely to utilize skilled delivery attendants. This finding is consistent with study done on utilization of skilled birth attendant at delivery in Mekele, which revealed that, women who have any visit to health facility were three times more likely to utilize skilled delivery attendant than those who did not have any visit to health facility. This could be explained by; those who visit health facility may have the chance to get information on the importance utilization of skilled delivery attendant which can help them to make informed decision on the delivery plan.

Women's attitudes towards skilled delivery services have shown significant association with utilization of skilled birth attendants. Women who have favorable attitudes towards SBA were 4 times more likely to use skilled attendants during delivery than women with unfavorable attitudes. This finding is in line with study conducted on factors determine delivery practice of pregnant women in Jima town (37).

8: CONCLUSIONS AND RECOMMENDATIONS

8.1: Conclusion

1- Skilled delivery service utilization was found to be low and distribution varied among the different socio-demographic and obstetric factors.

2- Maternal education, Residence, Health facility visit during last pregnancy, Number of pregnancy and attitude of mothers towards skilled birth attendant utilization were other determinants that influence the use of skilled birth assistance.

8.2: Recommendations

Based on the finding of the study, the following recommendations were forwarded to all concerned bodies: -

1- As women's education is an important predictor for their utilization of skilled delivery attendant, therefore GOs, NGOs and other stakeholders, like women association need to give great emphasis to girl's education.

2- Health professionals be supposed to strengthen in providing information on the importance of skilled delivery attendant at every child birth, for every woman who came to health facility and at ANC visit.

3- TBAs are highly accepted by the community since majority of the births were assisted by them (65%). Then health extension workers need to establish the system on how to integrate TBAs on providing maternal health care information rather on giving birth assistance.

4- All women should have access to skilled care during pregnancy and at delivery to ensure detection and management of complications and referral. Therefore, the government and NGOs in the woreda need to give training on midwifery skill for health extension workers in order to reach the disadvantaged women.

5- The government and other responsible bodies should make efforts to increase community based health education, awareness creation and improve better access to information for mothers regarding maternal health care should be strengthened.

6- Further qualitative studies need to be undertaken to explore the existing maternal health care services utilization.

9: LIMITATION

- The questionnaire tried to assess the use of skilled delivery services utilization in the last two years preceding the survey which might have introduced recall bias.

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11: ANNEXES

Annex 1: English questionnaire

Information Sheet and Consent Form

Title of the Research Project

Skilled delivery service utilization and associated factors among mothers who gave birth in the last 2 years in Chilga woreda North Gondar Zone, North west Ethiopia.

Name of principal investigator: Mulawshum Zewdu

Name of the organization: School of Public Health, Gondar College of Medicine and Health Sciences, University of Gondar.

Name of the sponsor: Self

Introduction: This information sheet and consent form is prepared to explain the purpose of this research in order to get your willingness to participate in the study. The main aim of this research project is to assess skilled delivery service utilization and associated factors among women who gave birth in the last2 years. The research team includes principal investigator, eight 12 grade complete students, two Supervisors and two advisors from University of Gondar.

Purpose of the research project: The aim of this study is to assess skilled delivery service utilization and associated factors among women who gave birth in the last 2 years. Assessing the factors which influence skilled delivery service utilization is helpful to design appropriate intervention programs aimed at improving the utilization of the service to improve maternal and newborn health status.

Procedure: For this study a structured and pretested questionnaire will be used to interview the mothers. The study involves women who gave birth in the last 2 years; since you fulfill the criteria, the team has selected you to be one of the study participants. If you are willing to participate, you are kindly requested to give your genuine response to the data collectors during interview.

Risk and /or discomfort: By participating in this research project you may feel that it has some risk or discomfort but there is no major risk or discomfort. The interview will take 30 - 40 minutes.

Benefits: There is no direct benefit to you in participating in this research but it helps us in assessing the factors that affect skilled delivery service utilization and to design better intervention to improve service utilization in the study area.

Incentives/payments for participating: You will not be provided any incentives or payment to take part in this project.

Confidentiality: The information collected from you will be kept confidential. It will be stored in a file using codes, without your name. And it will not be revealed to anyone except the principal investigator. In addition it will be used only for this particular research but not other purposes.

Right to refusal or withdraw: You have the full right to refuse from participating in this research. You can choose not to answer any or all the questions and this will not affect you and your family from getting any kind of delivery care service. You have also the full right to withdraw from this study at any time you wish, without losing any of your right.

Person to contact: This research project will be reviewed and approved by the institutional review board of school of public health, university of Gondar. If you want to know more information, you can contact the following individuals and you may ask at any time you want.

1. Ato. Mulawshum Zewdu,
   Mobile: +251918707838 / e-mail:mulawzewdu@yahoo.com
2. Dr.Getu Degu, University of Gondar
   Mobile: +2519776010
3. Ato Dagnew Engda, University of Gondar
   Mobile: +251918350017

I understood about the advantage of the research and the roles I will have in the research. I have agreed to participate in the research.

A. Yes B. No

If respondent agrees to be interviewed,

Starting time_____: End time_____:

001. Questionnaire Code _____

002. Residence 1. Urban 2. Rural

003. How long you have been living here?

1. 6 months and above

2. Less than 6 months ⟶ go to next house

Date of data collection----------

Name of data collector---------- signature----------

Part I Socio demographic factors

No	Questions	Choice Answers	Skip to ...
101	Age	in years----------	
102	Marital status	1. Married 2. Divorced 3. Widowed 4. single 5. Separated	
103	Religion	1. Orthodox 2. Protestant 3. Muslim 4. others, specify----------88	
104	Ethnicity	1. Amhara 2. Oromo 3.Tigre 4. Others, specify----------88	
105	What is your occupation?	1. House wife 2. Gov't Employee 3. Private Employee 4. farmer 5. merchant 6. daily labourer 7. Others, specify---------- 88	
106	Educational Status of the mother	1. unable to read and write 2. Read and write 3.primary education(1-8) 4. secondary education (9-12) 5. College and above	
107	Average monthly family income (for urban mother)	in birr----------	
108	Annual amount of crops for rural	Teff----------	

	mothers produced in the last 12 months (in quintals)	Bokolo---------- Mashla ---------- Potato---------- Others, specify ----------88	
109	Number of animals for rural mothers (in number)	Oxen ---------- Cows---------- Sheep ---------- Goats---------- Chicken ---------- Others, specify----------88	
110	Family size	In number ----------	
111	Age of your husband?	In years----------	
112	Husbands educational Status	1. unable to read and write 2. Read & write 3. Primary education(1-8) 4. Secondary(9-100 5. college and above	
113	Husbands occupation	1. Farmer 2. Gov't employee 3. private employee 4. Merchant 5. daily labourer 6. Other, specify----------88	
114	Do you have any of the following means of communication?	1. radio 2. TV 3. none 4.others, specify----------88	
115	Distance from the nearby health center	Less than 1 hour 1-2 hours More than 2 hours	

Part II Obstetric factors

201	Age at first marriage (at first union)	In years----------	
202	Age at first pregnancy	In years----------	
203	Total number of pregnancy (gravidity)	In numbers----------	
204	Total number of births (parity)	In numbers ----------	
205	Number of live births	In numbers----------	
206	Number of abortions ever had before the last birth	In numbers----------	
207	Number of still births ever had before the last birth	In numbers----------	
208	Have you ever visited health facilities during pregnancy?	Ye 2. No	
209	If yes what were the reasons to visit health facilities?	1. For ANC services 2. For delivery 3. For pregnancy related problem 4. For problems not related to pregnancy 5. Others, specify ----------88	
210	Did you have any visit to health facility during your last pregnancy?	1.Yes 2. No	
211	What were your reasons to visit health facility during your last pregnancy?	1. For ANC care 2. For delivery 3. For pregnancy related problem 4. For problems not related to pregnancy 5. Others, specify ----------88	
212	If your visit was for ANC, number of visits	In number----------	
213	Where did you attend ANC follow up?	1. Health Center	

		2. Health post 3. Hospital 4. Other, specify ----------88	
214	During ANC follow up did get any information about pregnancy & delivery Complications?	1. Yes 2. No 3. I don't know	
215	If yes, what types of information?	1.severe vaginal bleeding 2. severe Head ache 3. Marked & fast weight signs 4. fetal movement cessation 5. prolonged labour 6. retained placenta 7. Other, specify----------88	
216	During ANC follow up, did you get any information about where to deliver?	1. Yes 2. No	
217	Was your last pregnancy planned?	1.Yes 2.No	

Part III Questions related to the Last delivery

301	Did your last birth result in alive baby or still birth?	1. alive 2. Still birth	
302	**Where did you deliver your last birth?**	**1. Home** **2. Health facility** ⟶	Skip to Qn 305
303	If Home, why did you prefer to deliver in home?	1. I feel more comfortable giving birth in home 2. Close attention from my relatives and families 3. Because it is my usual practice 4. I don't like the service in health facilities	

		5. I have bad experience in giving birth in health facilities 6. Unwelcoming approach of health workers in health facilities 7. the health facility is too far from my house 8. labour was urgent to reach health facilities 9. lack of money for transport 10. influenced by my husband not go to health facilities 11. family members prefer to give birth in home 12. others reasons, specify----------88	
304	Who assisted you during your last delivery at home?	1. No one 2. Health Professionals (skilled attendant) 3. Trained TBAs 4. Untrained TBAs 5. health extension worker 6. Family or relatives 7.Others, specify----------88	
305	If your answer to 302 is health facility, why did you choose to deliver in Health facility?	1. To get better services in health facilities 2. To get better outcomes from health facilities to me and my baby 3.Bad experience from past home delivery 4.I was informed to deliver in health facilities 5. The health facility closer to my home 6. Others, specify----------88	
306	If you gave birth in health facilities, which health facility?	Health center Hospital Health post Private clinic	

Part IV Questions related to knowledge on pregnancy and delivery

401	Are the following pregnancy and delivery related services are given in health facilities?	Yes No ANC services ----------1 2 Delivery services ----------1 2 PNC services ----------1 2 Prevention of delivery complications----------1 2 Managing delivery complications----------1 2 Managing health problem of the New Born------1 2	
402	What do you think the advantages of pregnancy and delivery related services?	Yes No For anticipating problems----------1 2 For early detection of health Problems----------1 2 For appropriate management of health problems1 2 For better health care to the women----------1 2 For better care to the newborn ----------1 2	
403	What complications do you know that can occur during pregnancy?	Yes No Vaginal bleeding ----------1 2 Severe headache ----------1 2 Severe abdominal pain ----------1 2 Marked & fast weight gain----------1 2 Amniotic fluid leakage----------1 2 Absence of fetal movement----------1 2	
404	Who are do you think susceptible for pregnancy and delivery complications?	Yes No 1.Every mother including myself ---------- 1 2 2.Primi-mothers---------- 1 2 3.Multi gravid mothers (5 and more)----------1 2 4.Mothers with multiple pregnancy----------1 2 5.Mothers with other medical problems----------1 2	
405	What are the complications that can occur during	1. severe haemorrhage 2.retained placenta (lasting more than 30 minutes)	

	delivery?	3. prolonged labour (lasing more than 12 hours) 4. loss of consciousness	

Part V- Questions related to attitude towards Skill birth attendance and home delivery

501	Giving birth in health facilities with skilled attendants has better outcomes to mother.	1. Agree 2. Disagree 3. Neutral	
502	Giving birth in health facilities with skilled attendants has better outcomes to her new born.	1. Agree 2. Disagree 3. Neutral	
503	Giving birth in home is may be risky for the mother.	1. Agree 2. Disagree 3. Neutral	
504	Giving birth in home is may be risky for the newborn.	1. Agree 2. Disagree 3. Neutral	
505	If a mother delivers in health facilities with skilled attendants complications (like retained placenta, prolonged labour, bleeding) can be managed.	1. Agree 2. Disagree 3. Neutral	
506	In my opinion mothers can be attended by male skilled attendants during delivery.	1. Agree 2. Disagree 3. Neutral	
507	During delivery I don't prefer to be attended by traditional birth attendants.	1. Agree 2. Disagree 3. Neutral	

508	During delivery every mother should be attended by skilled birth attendants.	1. Agree 2. Disagree 3. Neutral	
509	During delivery I don't prefer to be attended by somebody from my family members.	1. Agree 2. Disagree 3. Neutral	
510	Delivery complication can be severe and may be hazardous to my well being	1. Agree 2. Disagree 3. Neutral	
511	Delivery complication can be severe and may be hazardous to the newborn.	1. Agree 2. Disagree 3. Neutral	
512	Do you think service providers provide comfortable and quality care servicee during delivery ?	1. Agree 2. Disagree 3. Neutral	

Part VI Question related to household decision making autonomy of the mother

601	Did you discuss with your partner about where to deliver during your last delivery?	1. yes 2. No	
602	What was your preference of delivery place during your last delivery?	1. Home 2. Health facilities 3.other places, specify----------88	
603	What was your husband's preference about delivery place during your last delivery?	1. home 2. Health facilities 3. other places,specify----------88	
604	What was your preference about attendant	1. SBA	

	of delivery during your last delivery?	2. TTBA 3. TBA 4. Family member or relatives 5. Others, specify----------88	
605	What was your husband's preference about attendant of delivery during your last delivery?	SBA TTBA TBA Family member or relatives Others, specify----------88	
606	What was the preference of other family members about place of delivery during your last delivery?	1.home 2. Health facilities 3. Other, specify----------88	
607	What was the preference of the community about the place of delivery during your last delivery?	1. home 2. Health facilities 3. Others, specify----------88	
608	Who was finally made decision about your delivery place during your last delivery?	1.Myself 2.my husband 3.Both me & my husband 4.Others, specify----------88	

ጥናቱን በተመለከተ መረጃ መስጫ እና ማስፈረሚያ ቅጽ

የጥናቱ ርእስ: ከጥናቱ በፊት ባሉት ሁለት አመታት ዉስጥ በሰለጠኑ የጤና ባለሙያዎች በወለዱ እናቶች የነበረዉ የወሊድ አገልግሎትና ተያያዥነት ያላቸዉ ሁኔታዎች፣በጭልጋ ወረዳ፣ ሰሜን ጎንደር ዞን፣ ሰሜን ምዕራብ ኢትዮጵያ፡፡

የአጥኝዉ ስም : ሙላዉሹም ዘዉዱ

የሚያስጠናዉ ድርጅት ስም: ጎንደር ዩኒቨርሲቲ፣ የህክምናና ጤና ሳይንስ ኮለጅ፣ የህብረተብ ጤና ትምህርት ክፍል

የጥናቱን ወጭ የሚሸፍነዉ ድርጅት ስም: በአስጠኙ የሚሸፈን

መግቢያ: ይህ የመረጃ መስጫ እና ማስፈረሚያ ቅጽ የተዘጋጀዉ ስለጥናቱ አላማ ለመግለጽና የእናንተን በጥናቱ የመሳተፍ ፈቃደኝነት ለመጠየቅ ነዉ፡፡ የዚህ ጥናት ዋና አላማ ከጥናቱ በፊት ባሉት ሁለት አመታት ዉስጥ በሰለጠኑ የጤና ባለሙያዎች በወለዱ እናቶች የነበረዉ የወሊድ አገልግሎትና ተያያዥነት ያላቸዉ ሁኔታዎች ምን ይመስል እንደነበረ ለማወቅ ነዉ፡፡ በዚህ ጥናት የጥናቱ ዋና መሪ፣ስምንት 12ኛ ክፍል የጨረሱ ተማሪዎች፣ 2 የሚሰበሰበዉን መረጃ ጥራት የሚከታተሉ ነርሶች፣ እንዲሁም 2 የጥናቱ አማካሪዎች ይሳተፋሉ፡፡

የጥናቱ አላማ፡ የዚህ ጥናት ዋና አላማ በሰከላ ወረዳ ከጥናቱ በፊት ባሉት ሁለት አመታት ዉስጥ በሰለጠኑ የጤና ባለሙያዎች በወለዱ እናቶች የነበረዉ የወሊድ አገልግሎትና ተያያዥነት ያላቸዉ ሁኔታዎች ምን ይመስል እንደነበረ ለማወቅ ነዉ፡፡ በወሊድ አገልግሎት ላይ ተጽእኖ ሊያደርጉ የሚችሉ ሁነታዎችን ለይቶ ማወቅ የተሻለ ፕሮግራም ለመንደፍና እርምጃ ለመዉሰድ ብሎም አገልግሎቱን ለማሻሻል እንዲሁም የእናቶችንና የሚወለዱትን ህጻናት የጤና ሁኔታ ለማሻሻል ይረዳል፡፡

የአሰራር ሁኔታ (ሂደት):
በጥናቱ የሚሳተፉ እናቶችን ለመጠየቅ አስቀድሞ የተዘጋጀና ጥራቱ በሙከራ የተፈተሸ መጠይቅ እንጠቀማለን፡፡ ጥናቱ በአለፉት ሁለት አመታት ዉስጥ የወለዱ እናቶችን ብቻ ያጠቃልላል፡፡ እርስዎ የመሳተፊያ መለኪያዉን ስላሟሉ ለጥናቱ ተመርጠዋል፡፡ ለመሣተፍ ፈቃገኛ ከሆኑ፣ ለቃለመጠይቁ የእርስዎን እዉነተኛ መልስ እንዲሰጡን እንጠይቃለን፡፡ የእርስዎ ተሳትፎ ይበረታታል፡፡
ሊመጡ የሚችሉ ችግሮች: በጥናቱ በመሳተፍዎ ችግር ያለዉ ሊመስልዎት ይችላል ነገር ግን ሊጠቀስ የሚችል ምንም አይነት ችግር የለዉም፡፡ መጠይቁ ከ30 እስከ 40 ደቂቃ ሊወስድ ይችላል፡፡
ጥቅሞች: በጥናቱ በመሳተፍዎ ምንም አይነት ቀጥተኛ የሆነ ጥቅም አያገኙም፡፡ ነገር ግን በጭልጋ ወረዳ በወሊድ አገልግሎት ላይ ተጽእኖ ሊያደርጉ የሚችሉ ሁኔታዎችን መለየት የተሻለ ፕሮግራም ለመንደፍና እርምጃ ለመዉሰድ ይረዳል፡፡

የማካካሻ ክፍያ/ስለተሳትፎዎ ክፍያ: ስለተሳትፎዎ ምንም አይነት የማካካሻ ክፍያ አይከፈልዎትም፡፡

የመረጃዉ ምስጢራዊነት: ከእርስዎ የሚሰበሰበዉ መረጃ ምስጢራዊነቱ የተጠበቀ ነዉ። ስምዎ ወይም የእርስዎን ማንነት ለመለየት የሚያስችል መረጃ አይጠየቁም። መረጃዉ የሚቀመጠዉ በምስጢራዊ ኮድ ነዉ። ጥናቱን ከሚሰሩት ሰዎች ዉጭ መረጃዉ ለማንም አይሰጥም። መረጃዉ ለታቀደለት ጥናት ብቻ ይዉላል።

የመዉጣት/የማቋረጥ መብት: በጥናቱ ያለመሳተፍ መብትዎ የተጠበቀ ነዉ። ማንኛዉንም መመለስ ያልፈለጉትን ጥያቄ ወይም ሁሉንም መመለስ ካልፈለጉ እንዲመልሱ አይገደዱም። ባለመመለስዎ በእርስዎም ሆነ በቤተሰብዎ የሚመጣብዎት ምንም ችግር የለም። ጥናቱን አቋርጦ መዉጣት ከፈለጉ ሙሉ መብትዎ የተጠበቀ ነዉ።

ተጨማሪ መረጃ ከፈለጉ: ይህ ጥናት በጎንደር ዩኒቨርሲቲ ህብረተሰብ ጤና ትምህርት ክፍል ተፈትሾ ተቀባይነትዉ ጸድቋል። ጥያቄ ካለዎትና ተጨማሪ መረጃ ከፈለጉ በማንኛዉም ጊዜ ከዚህ በታች የተጠቀሱትን አድራሻዎች መጠቀም ይችላሉ።

1. አቶ መላዉሹም ዘዉዱ፣

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2. ዶ/ር ጌጡ ደጉ፣ ጎንደር ዩኒቨርሲቲ

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3. አቶ ዳኘዉ እንግዳዉ፣ ጎንደር ዩኒቨርሲቲ

   ስልክ: +251918350017

የዚህ ጥናት ዓላማ ተነቦልኝ (አንብቤው) እና ዓላማው ገብቶኝ በጥናቱ ለመሣተፍ፡

ሀ. ፈቃደኛ ሆኛለሁ ለ. ፈቃደኛ አይደለሁም

የተጠያቂው ስም ..... ፊርማ.....

ተጠያቂ ው ለመሳተፍ ፈቃደኛ ከሆነ፣ የተጀመረበት ጊዜ _____ ያለቀበት ጊዜ _____

001. የቃለ መጠይቁ ኮድ _____

002. መኖሪያ 1. ከተማ

2. ገጠር (የቀበሌው ስም ይጻፍ) ----------

003. እዚህ ለምን ያህል ጊዜ ኖረዋል?

1. 6 ወርና ከዚያ በላይ

2ከ6ወርበታች ——————→ ወደ ሚቀጥለው ቤት ይሂዱ

መረጃዉ የተሰበሰበበት ቀን----------

መረጃዉን የሰበሰበዉ ሰዉ ስም---------- ፊርማ----------

የመረጃዉን ጥራት የተቆጣጠረዉ ሰዉ ስም---------- ፊርማ----------
-

ክፍል 1. አጠቃላይ ማህበራዊ ነክ መረጃዎች

ተ.ቁ.	ጥያቄዎች	አማራጭ መልሶች	ወደጥያቄ ቁጥር...ይለፉ
101	የእናት እድሜ	በዓመት----------	
102	የጋብቻ ሁኔታ	1. ያገባች (አሁን አብረው የሚኖሩ) 2. ከባሏ የተፋታች 3. ባሏ የሞተባት 4. እስካሁን ያላገባች 5. ከባሏ ጋር ተለያይተዉ የሚኖሩ(በስራ ምክንያት)	
103	ሐይማኖት	1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. እስላም 4. ሌላ፣ይጠቀስ----------88	
104	ብሄር	1. አማራ 2. ኦሮሞ 3.ትግሬ 4. ሌላ፣ ይጠቀስ----------88	
105	የእናት የስራ ሁኔታ	1. የቤት እመቤት 2. የመንግስት ሰራተኛ 3. የግል ድርጅት ሰራተኛ 4. አርሶ አደር 5. ነጋዴ 6. የቀን ሰራተኛ 7. ሌላ፣ ይጠቀስ----------88	
106	የእናት የትምህርት ሁኔታ	1. ማንበብና መጻፍ የማትችል 2. ማንበብና መጻፍ የምትችል 3. የመጀመሪያ ደረጃ ትምህርት ያጠናቀቀች (1-8) 4. ሁለተኛ ደረጃና ከዚያ በላይ(9-12+)	
107	የባለቤትዎ የትምህርት ሁኔታ?	**ከላይ በቁጥር 106 ከተሰጡት ይምረጡና ይጻፉ**----------	

108	አማካኝ የወር ገቢ (ለከተማ እናቶች ብቻ)	በብር----------	
109	በአለፈው አመት የተመረተ አማካኝ አመታዊ የአዝዕርት መጠን (ለገጠር እናቶች በኩንታል)	ጤፍ---------- ቦቆሎ---------- ማሽላ---------- ድንች---------- ሌሎች፣ ይጠቀሱ----------88	
110	የቤት እንስሳት ብዛት (ለገጠር እናቶች በቁጥር)	በሬ ---------- ላሞች---------- በጎች ---------- ፍየሎች---------- ዶሮዎች ---------- ሌሎች፣ ይጠቀሱ----------88	
111	የቤተሰብ ብዛት	በቁጥር ----------	
112	የባለቤትዎ እድሜ	በዓመት ----------	
113	የባለቤትዎ የስራ ሁኔታ	1.አርሶ አደር 2. የመንግስት ሰራተኛ 3. የግል ድርጅት ሠራተኛ 4. ነጋዴ 5. የቀን ሰራተኛ 6. ሌላ፣ይጠቀስ----------88	
114	ከሚከተሉት ውስጥ የትኞቹ የመረጃ ምንጮች አላችሁ?	1. ሬዲዮ አለን 2. ቴሌቪዥን አለን 3. ምንም የለንም 4.ሌሎች፣ይጥቀሱ----------88	
115	ቤትዎ በቅርበት ካለው ጤና ጣቢያ ያለው ርቀት (በሰዓት)	ከ1 ሰዓት በታች ይወስዳል ከ1 እስከ 2 ሰዓት ይወስዳል ከ2 ሰዓት በላይ ይወስዳል	

ክፍል 2 ከወሊድ ጋር የተያያዙ ጥያቄዎች

201	ለመጀመሪያ ጊዜ ትዳር ሲመሰርቱ እድሜዎ ስንት ነበር (ከባለቤትዎ		

	ጋር በአንድ ቤት አብራችሁ መኖር የጀመራችሁበትን)?	በአመት ---------	
202	ለመጀመያ ጊዜ ነፍሰ ጡር ሲሆኑ እድሜዎ ስንት ነበር?	በአመት----------	
203	እስካሁን ድረስ ምን ያህል ጊዜ አርግዘዋል(ዉርጃ ካለ ይጨምራል)?	በቁጥር--------	
204	እስካሁን ድረስ ምን ያህል ጊዜ ልጆች ወልደዋል(በህወት የሌሉትንም ይጨምራል)?	በቁጥር----------	
205	ከወለዷቸዉ ውስጥ ምን ያህሉ በህይወት ተወለዱ?	በቁጥር----------	
206	ከመጨረሻ ወሊድ በፊት ውረጃ ካለ ምን ያህል ጊዜ አጋጥሞዎታል?	በቁጥር----------	
207	ከመጨረሻ ወሊድ በፊት ሞቶ የተወለደ ልጅ ካለዎት ምን ያህል ጊዜ አጋጥሞዎታል?	በቁጥር----------	
208	በህይወት ዘመንዎ ነፍሰ ጡር እያሉ ወደ ጤና ተቋማት ሂደዉ ያዉቃሉ?	1.አዎ 2. አልሄድኩም	
209	መልስዎ አዎ ከሆነ ወደ ጤና ተቋም የሄዱበት ምክንያት ምንድን ነበር?	አዎ አይደለም 1.ለቅድመ ወሊድክትትል----------1 2 2. ለመዉለድ ----------1 2 3. በእርግዝናየ ምክንያት ስላመመኝ----------1 2 4. ከእርገግዝናየ ጋር ግንኙነት የሌለዉ ሌላ ህመም ስላመመኝ----------1 2 5.ሌሎች፣ይጥቀሱ ----------88	
210	በመጨረሻዉ የእርግዝናዎ ወቅት ወደ ጤና ተቋም ሄደዋል?	1. አዎ 2. አልሄድሁም	
211	መልስዎ አዎ ከሆነ በመጨረሻዉ የእርግዝናዎ ወቅት ወደ ጤና ተቋም የሄዱበት ምክንያት ምንድን ነበር?	አዎ አይደለም 1. ለቅድመ ወሊድ ክትትል ----------1 2 2. ለመዉለድ ----------1 2 3. በእርግዝናየ ምክንያት ስላመመኝ ----------1 2	

		4. ከእርገግዝናየ ጋር ግንኙነት የሌለዉ ሌላ ህመም ስላመመኝ----------1 2 5. ሌሎች፣ይጥቀሱ ----------88	
212	ወደ ጤና ተቋም የሄዱበት ምክንያት ለቅድመ ወሊድ ክትትል ከሆነ እስከሚወ ልዱ ድረስ ለምን ያህል ጊዜ ሄደዋል?	1. አንድ ጊዜ ብቻ 2. ከሁለት እስከ አራት ጊዜ 3. ከአራት ጊዜ በላይ	
213	የእርግዝና ክትትል ያደረጉት የት ነበር?	1. ጤና ጣቢያ 2. ጤና ኬላ 3. ሌላ ቦታ ፣ይጥቀሱ ----------88	
214	በእርግዝና ክትትል ወቅት በእርግዝናና በወሊድ ምክንያት ስለሚመጡ ተያያዥ ችግሮች መረጃ ከጤና ባለሙያዎች አግኝተዉ ነበር?	1. አዎ 2. አላገኘሁም 3. እኔ አላዉቅም	
215	መልስዎ አዎ ከሆነ በእርግዝናና በወሊድ ምክንያት ስለሚመጡ ተያያዥ ችግሮች ከጤና ባለሙያዎች ምን ምን መረጃዎችን አግኝተዉ ነበር? **(ከአንድ በላይ መልስ)**	አዎ አይደለም 1.በማህጸን ጫፍ ከፍተኛ የደም መፍሰስ---------1 2 2. ከፍተኛ ራስ ምታት ----------1 2 3. በእርግዝና ወቅት ፈጣንና ከፍተኛ የሆነ የክብደት----------1 2 4. የጽንሱ ልብ ምት ማቆም----------1 2 5. ምጥ ከጀመረ በኃላ ቶሎ አለመዉለድ (ከ12ሰዓት በላይ መቆየት)----------1 2 6.የእንግዴ ልጅ ቶሎ አለመዉረድ (ከ30 ደቂቃ በላይ መቆየት)----------1 2 7.ሌሎች መረጃዎች ፣ይጠቀሱ----------88	
216	በእርግዝና ክትትልዎ ወቅት የት መዉለድ እንዳለብዎ ከጤና ባለሙያዎች መረጃ አግኝተዉ ነበር?	1. አዎ 2. አላገኘሁም 3. እኔ አላዉቅም	

217	የመጨረሻውን እርግዝናዎትን ያረገዙት ልጅ ለመውለድ አቅደዉ ነበር?	አዎ አቅጀ ነበር የታቀደ አልነበረም	

ክፍል 3. የእናቶችን እስካሁን ካሉት የመጨረሻውን /በቅርብ ጊዜ የነበረውን/ ወሊድ የሚመለከቱ ጥያቄዎች

301	በቅርብ ጊዜ የወለዱት ልጅ በህይወት ነው የተወለደው ወይስ ሞቶ የተወለደ ነው?	1. በህይወት ነው የተወለደው 2. ሞቶ ነው የተወለደዉ	
302	**በቅርብ ጊዜ የወለዱትን ልጅ የት ነው የወለዱት?**	**1. ጤና ተቋም** ⟶ **2. ቤት ውስጥ**	**ወደ ጥያቄ ቁጥር 305 ይለፉ**
303	በቅርብ ጊዜ የወለዱትን ልጅ የወለዱት ቤት ውስጥ ከሆነ ቤትዎ ውስጥ ለመውለድ የመረጡበት ምክንያት ምንድን ነበር? **(ከአንድ በላይ መልስ)**	አዎ አይደለም ከራሴ ቤት ውስጥ ስወልድ የተሻለ ምቾት ስለሚሰማኝ----------1 2 ቤተሰቦቸ እና ዘመዶቸ በቅርበት ስለሚከታተሉኝ----------1 2 ሁሌም የምወልደው ቤቴ ውስጥ ስለሆነ----------1 2 ጤና ተቁዋማት ውስጥ የሚሰጠውን የወሊድ አገልግሎት ስለማልወደው----------1 2 ጤና ተቋም ውስጥ መጥፎ ገጠመኝ ስላለኝ----------1 2 የጤና ባለሙያዎች አቀራረብ ስለማይመቸኝ----------1 2 በምኖርበት አካባቢ በቅርበት ጤና ጣቢያ ስለሌለ----------1 2 ምጡ ፈጣን ስለነበር ጤና ጣቢያ ሳልደርስ በመውለዴ----------1 2 የትራንስፖረት የሚሆን ገንዘብ ስላልነበረኝ ----------1 2 ባለቤቴ ጤና ጣቢያ ውስጥ እንድወል ስላልፈቀደልኝ ----------1 2 ሌሎች የቤተሰቡ አባላት ቤት ውስጥ እንድወልድ----------1 2 -ሌሎች ምክንያቶች፣ ይጠቀሱ---------- 88	

304	በቅርብ ጊዜ የወለዱትን ልጅ ቤት ውስጥ ሲወልዱ ያዋለድ-ዎ ማን ነበር?	1. ማንም አላዋለደኝም 2. የጤና ባለሙያ 3. የሰለጠነች የልምድ አዋላጅ 4. ያልሰለጠነች የልምድ አዋላጅ 5. የጤና ኤክስቴንሽን ባለሙያ 6. ቤተሰቦቸ/ዘመዶቸ 7.ሌላ ሰው፤ ይጠቀስ----------88	
305	ለጥያቄ 302 መልስዎ ጤና ተቋም ውስጥ ከሆነ ጤና ተቋም ውስጥ ለመውለድ የመረጡበት ምክንያት ምን ነበር? **(ከአንድ በላይ መልስ)**	አዎ አይደለም በጤና ተቋማት ውስጥ የተሻለ የወሊድ አገልግሎት ስለማገኝ----1 ነ 2 በጤና ተቋማት ውስጥ መውለድ ለእኔም ለልጀም የተሻለ ውጤት ስላለው ----------1 2 ባለፈው ቤት ውስጥ ስወልድ መጥፎ አጋጣሚ ስለነበረኝ ----------1 2 ጤና ተቋም ውስጥ እንድወልድ ከጤና ባለሙያ ምክር ስላገኘሁ----1 2 ጤና ተቋሙ ለቤቱ ቅርብ ስለሆነ----------1 2 የጤና ባለሙያዎች አቀራረብ ስለሚመቸኝ ----------1 2 ሌላ ምክንያት ይጠቀስ----------88	
306	የትኛው ጤና ተቋም ውስጥ ነበር የወለዱት?	1.ጤና ጣቢያ 2. ሆሰፒታል 3. ጤና ኬላ 4. የግል ጤና ተቋም	

ክፍል 4 ስለ እርግዝናና ወሊድ የእናቶችን እውቀት የሚዳስሱ ጥያቄዎች

401	በጤና ተቋማት ውስጥ እርግዝናና ወሊድን የተመለከቱ ምን ምን አገልግሎቶች ይሰጣሉ? **(ምርጫዎች አንድ በአንድ ይነበባሉ)**	አዎ አይደለም 1.የቅድመ ወሊድ ክትትል አገልግሎት----------1 2 2.የወሊድ አገልግሎት ----------1 2 3.ድህረ ወሊድ አገልግሎት ----------1 2 4.በወሊድ ምክንያት የሚመጡ ተያያዥ ችግሮችን መከላከል-1 2 5. በወሊድ ምክንያት ለሚመጡ ተያያዥ ችግሮች ህክምና መስጠት----------1 2	

		6.የሚወለደው ህጻን ችግር ካጋጠው ህክምና ለመስጠት-----1 2	
402	በጤና ተቋማት ውስጥ ለእናቶች በእርግዝናና በወሊድ ጊዜ የሚሰጡ አገልግሎቶች ምን ምን ጥቅም ይሰጣሉ ብለዉ ያስባሉ? **(ምርጫዎች አንድ በአንድ ይነበባሉ)**	አዎ አይደለም 1.ሊመጡ የሚችሉ ችግሮችን ቀድሞ ለመገመት----------1 2 2.ችግሮች ሲከሰቱ ቀድሞ ለማወቅ----------1 2 3.ችግሮች ሲፈጠሩ ተገቢውን ህክምና ለማድረግ----------1 2 4. ለእትናየዋ ጤና የተሻለ አገልግሎት ለማግኘት----------1 2 5. ለህጻኑ ጤና የተሻለ አገልግሎት ለማግኘት----------1 2	
403	በእርግዝና ጊዜ ምን ምን ተያያዥ የጤና ችግሮች ሊከሰቱ ይችላሉ ብለዉ ያስባሉ? **(ምርጫዎች አንድ በአንድ ይነበባሉ)**	አዎ አይደለም 1. በማህጸን ጫፍ ከፍተኛ የደም መፍሰስ ----------1 2 2. ከፍተኛ ራስ ምታት ----------1 2 3. ከፍተኛ የሆነ የሆድ ህመም----------1 2 4. ፈጣንና ከፍተኛ ሆነ የክብደት መጨመር ----------1 2 5. የእንሽርት ውሀ ምጥ/ የወሊድ ጊዜ ሳይደርስ መፍሰስ---1 2 6. የጥንሱ እንቅስቃሴ ማቆም ----------1 2	
404	በእርግዝናና በወሊድ ምክንያት የሚመጡ ተያያዥ የጤና ችግሮች የተጋለጡ የተኖቹ እናቶች ናቸው ብለዉ ያስባሉ? **(ምርጫዎች አንድ በአንድ ይነበባሉ)**	አዎ አይደለም 1. እኔን ጨምሮ ሁሉም እናቶች ----------1 2 2. ለመጀመሪያ ጊዜ ያረገዙ እናቶች ----------1 2 3. ብዙ ጊዜ የወለዱ እናቶች(5 ጊዜ እና ከዚያ በላይ)--------1 2 4. ከአንድ በላይ/መንታ ያረገዙ እናቶች ----------1 2 5. ሌላ የጤና ችግር ያለባቸው እናቶች (ምሳሌ ስኳር በሽታ፣ የደም ግፊት)----------1 2	
405	በወሊድ ጊዜ የእንትዮዋን ህይወት ሊፈታተኑ የሚችሉ ምን ምን ተያያዥ የጤና ችግሮች ሊከሰቱ ይችላሉ ብለዉ ያስባሉ? **(ምርጫዎች አንድ በአንድ ይነበባሉ)**	አዎ አይደለም 1. በማህጸን በር ከፍተኛ ደም መፍሰስ----------1 2 2. የእንግዴ ልጅ ቶሎ አለመውረድ (ከ30 ደቂቃ በላይ ከቆየ)--1 2 3. የምጥ ጊዜ መራዘም (ከ12 ሰዓት በላይ ከቆየ)-------- -------1 2 4.ራስን/ህሊናን መሳት----------1 2	

ክፍል5. በሰለጠኑ ባለሙያዎች ስለመዉለድ፣ ስለ አዋላጅ የጤና ባለሙያዎች የእናቶችን አመለካከት/ዝንባሌ የሚመዝኑ ጥያቄዎች

501	በሰለጠኑ የጤና ባለሙያዎች ታግዞ መውለድ ለእናትዮዋ ጤና የተሻለ ጥቅም/ውጤት አለው ብለዉ ያስባሉ ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
502	በሰለጠኑ የጤና ባለሙያዎች ታግዞ መውለድ ለሚወለደው ልጅ ጤና የተሻለ ጥቅም/ውጤት አለው ብለዉ ያስባሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
503	ቤት ውስጥ መውለድ ለእናትዮዋ ጤና አስቸጋሪ ሁኔታዎች ሊኖሩት ይችላል ብለዉ ያስባሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
504	ቤት ውስጥ መውለድ ለሚወለደው ልጅ ጤና አስቸጋሪ ሁኔታዎች ሊኖሩት ይችላል ብለዉ ያስባሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
505	ነፍሰ ጡር እናቶች በጤና ተቋማት ውስጥ ከወለዱ የእናቶችን ህይወት ሊፈታተኑ የሚችሉ ተያያዥ የጤና ችግሮች ለምሳሌ የእንግዴ ልጅ ቶሎ አለመውረድ፣ከፍተኛ ደም መፍሰስ በቀላሉ ህክምና ሊደረግላቸው ይችላሉ ብለዉ ያስባሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
506	እንደ እኔ አመለካከት በወሊድ ጊዜ እናቶች እኔን ጨምሮ የወንድ የጤና ባለሙያ ሊያዋልዳቸው/ሊከታተላቸው ይችላል ብለዉ ያስባሉ ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
507	በወሊድ ጊዜ የልምድ አዋላጆች እንዲያዋልዱኝ/ እንዲከታተሉኝ አልመርጥም ይላሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
508	በወሊድ ጊዜ ሁሉም እናቶች እኔን ጨምሮ በሰለጠነ የጤና ባለሙያ/አዋላጅ መውለድ አለባቸው ይላሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
509	በወሊድ ጊዜ ከቤተሰብ አባላት አንድ ሰው እንዲያዋልደኝ አልመርጥም ይላሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
510	ከወሊድ ጋር ተያያዥ የሆኑ የጤና ችግሮች አደገኛና የእናትዮዋን/ለምሳሌ የራሴን/ ህይወት የሚፈታተኑ ሊሆኑ ይችላሉ ብለዉ ያስባሉ ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	

511	ከወሊድ ጋር ተያያዥ የሆኑ የጤና ችግሮች አደገኛና የሚወለደውን ልጅ ህይወት የሚፈታተኑ ሊሆኑ ይችላሉ ብለዉ ያስባሉ ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
512	በወሊድ ወቅት የጤና ባለሙያዎች አቀራረብ እና አገልግሎት አሰጣጥ ጥሩ ነዉ ብለዉ ያስባሉ?	1. እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	

ክፍል 6 በወሊድ ጊዜ የእናቶችን የመወሰን አቅም የተመለከቱ ጥያቄዎች

601	በመጨረሻ ለወለዱት ልጅ አርስዎ የት መውለድ እንዳለብዎት ከባለቤትዎ ጋር ተወያይታችሁ ነበር?	1. አዎ 2. አልተወያየንም	
602	በመጨረሻ ለወለዱት ልጅ እርስዎ የት እንዲወልዱ ነበር የመረጡት?	1. ቤት ዉስጥ 2. ጤና ጣቢያ 3. ሌላ ቦታ፣ ይጠቀስ----------88	
603	በመጨረሻ ለወለዱት ልጅ ባለቤትዎ የት እንዲወልዱ ነበር የመረጠው?	1. ቤት ዉስጥ 2. ጤና ጣቢያ 3. ሌላ ቦታ፣ ይጠቀስ----------88	
604	በመጨረሻ ለወለዱት ልጅ እርስዎ በወሊድ ጊዜ ማን እንዲያዋልድዎት/እንዲከታተልዎት/ ነበር የመረጡት?	የሰለጠነ የጤና ባለሙያ የሰለጠነ የልምድ አዋላጅ ያልሰጠነ የልምድ አዋላጅ ከቤተሰቦቸ ወይም ከዘመዶቸ አንዱ ሌላ ሰዉ፣ ይጠቀስ----------88	
605	በመጨረሻ ለወለዱት ልጅ ባለቤትዎ በወሊድ ጊዜ ማን እንዲያዋልድዎት /እንዲከታተልዎት/ነበር የመረጠው?	የሰለጠነ የጤና ባለሙያ የሰለጠነ የልምድ አዋላጅ ያልሰጠነ የልምድ አዋላጅ ከቤተሰቦቸ ወይም ከዘመዶቸ አንዱ ሌላ ሰዉ፣ ይጠቀስ----------88	
606	በመጨረሻ ለወለዱት ልጅ የሚወልዱበትን ቦታ በተመለከተ ሌሎች የቤተሰብ አባላት እርስዎ የት እንዲወልዱ ነበር የመረጡት?	1. ቤት ዉስጥ 2. ጤና ጣቢያ 3. ሌላ ቦታ፣ ይጠቀስ----------88	
607	በመጨረሻ ለወለዱት ልጅ የሚወልዱበትን ቦታ በተመለከተ የአካባቢዎ ማህበረሰብ እርስዎ የት	1. ቤት ዉስጥ	

	እንዲወልዱ ነበር የመረጠው?	2. ጤና ጣቢያ 3. ሌላ ቦታ፣ ይጠቀስ----------88	
608	በመጨረሻ ለወለዱት ልጅ የሚወልዱበትን ቦታ የመጨረሻ ዉሳኔ የወሰነዉ ማን ነበር?	እኔ እራሴ ባለቤቱ እኔ እና ባለቤቱ በጋራ ሌሎች ሰዎች፣ ይጥቀሱ----------88	

DECLARATION

I, the undersigned, senior MPH student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name: ----------

Signature: ----------

Place of submission: School of Public Health, College of Medicine and Health Sciences, University of Gondar

Date of submission: ----------

This thesis work has been submitted for examination with my/our approval as University advisor(s).

Advisors

Name	**Signature**
1. ----------	----------
2. ----------	----------